State of Montana
Department of Justice
Motor Vehicle Division

DRIVER MEDICAL EVALUATION

Name (Last, First, Middle)	Driver's License No.	Birth Date
Street address	City ZIP	Daytime or home phone number

RELEASE OF INFORMATION BY PATIENT

I hereby authorize my physician or hospital to answer any questions from the Motor Vehicle Division, or its employees relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to release any related information or records to the Motor Vehicle Division or its employees. Any expense involved is to be charged to me and not the State of Montana.

I hereby authorize the Motor Vehicle Division to receive any information relating to my physical or mental condition, and/or drug and/or alcohol use or abuse, and to use the same in determining whether I have the ability to operate a motor vehicle safely.

Signed: **X** _____ Date: _____

Witness: _____

A. INTRODUCTION TO PHYSICIAN

Motor Vehicle Division records indicate your patient may have a condition that could affect the safe operation of a motor vehicle. With your assistance, we hope to resolve the matter with a minimum of inconvenience to all concerned.

Your experience and knowledge of the patient's condition, results of medical examinations and treatment plans, will be of great value in assisting the department to determine a proper licensing decision. PLEASE ANSWER ALL QUESTIONS on this form that are applicable to your patient's condition. A physician reporting in good faith is immune from liability, civil or criminal penalties under Montana law §37-2-311, 37-2-312, MCA. The department has sole responsibility for any decision regarding the patient's driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.

The above individual is being referred to you due to: _____

B. DIAGNOSIS

Is the condition: ☐ Improving ☐ Stable ☐ Worsening or deteriorating ☐ Subject to change	
How long has this person been your patient?	Date of last examination:
Is your patient under a controlled medical program? Yes ☐ No ☐	How long has control been maintained?
Is the patient adhering to the medical regimen? Yes ☐ No ☐	If no, please explain:

C. MEDICATIONS

Please list any medication currently prescribed:

Would the side effects from the prescribed medication interfere with the safe operation of a motor vehicle? **Yes** ☐ **No** ☐

If yes, please describe:

_____

D. LAPSE OF CONSCIOUSNESS DISORDER

Please identify any disease or disorder including epilepsy, narcolepsy, diabetes, cerebral vascular disease, or any other impairment that may cause loss of consciousness or control of motor functions at any time. _____

_____

_____

Date of last episode_____

Is condition stabilized?___ **Yes** ☐ **No** ☐ _____

E. IMPAIRMENTS THAT ARE PRESENTLY SHOWN BY YOUR PATIENT

☐ Sporadic loss of conscious awareness
☐ Loss of consciousness
☐ Impaired motor function
☐ Reaction, or impairment due to change in medication or dosage
☐ Neurological or neuromuscular disease
☐ Diminished concentration
☐ Diminished judgment
☐ Memory loss
☐ Alzheimer's disease
☐ Confusion
☐ Other dementia
☐ Other metabolic disorder

Comments:_____

_____

F. IN YOUR OPINION, WOULD THE PATIENT'S PHYSICAL OR MENTAL CONDITION INTERFERE WITH THE PATIENT'S SAFE OPERATION OF A MOTOR VEHICLE?

Yes ☐ **No** ☐

If yes, please describe:_____

_____

1. Do you recommend any driving restriction or adaptive equipment that should be utilized to assist your patient? ☐ ☐

If yes, please describe:_____

2. Do you recommend the Motor Vehicle Division conduct periodic driving evaluation or have patient submit periodic medical reports to monitor changes? ☐ ☐

If so, how often?_____

_____

G. PHYSICIAN

PHYSICIAN'S SIGNATURE	PHYSICIAN'S NAME (PRINTED)	DATE
TYPE OF PRACTICE OR MEDICAL SPECIALTY	ADDRESS	TELEPHONE NUMBER

Please return completed form to:

Motor Vehicle Division
Att: Medical Unit
PO Box 201430
Helena Mt 59620-1430

20-1900 12/97
Supplemental Medical Statement
(Internet Version)